Cider house rules

POVL MUNK-JØRGENSEN
Unit for Psychiatric Research, Aalborg Psychiatric Hospital, Mølleparkvej 10, DK-9000 Aalborg, Denmark

The authors, two of them among the very grand "old" men – godfathers – in European community psychiatry, have written *The Cider House Rules for Community Psychiatry*, of which we bring some examples below:

- Money is critical for mental health care.
- A day-hospital may be paid for the number of people attending each day.
- It may need to become clear to the staff that it does matter, for example to their salary or to their promotion, whether they fulfil the agreed tasks or not.
- It is vital that senior staff can maintain an overall view of the system as a whole.
- Robust service changes, improvements that will last, take time.
- Time is also needed to progress from the initiation state of a change to the consolidation phase.
- Everyone involved needs to keep a clear focus on the fact that the primary purpose of mental health service is to improve outcomes for people with mental illness.
- Feedback can be based on comments or complaints received, or it can be formally invited, for example with service user satisfaction surveys.
- You will make mistakes and need to change the service as it develops.

Breaking news! In their obvious self evidence they, just like the originals – pinned up on the wall of the cider house by Olive Worthington – express the high level of wisdom which can be reached only after 25 years of experience. For the benefit of the reader, we bring three examples from the original list:

- Please don't smoke in bed or use candles.
- Please don't go up on the roof if you've been drinking – especially at night.
- There should be no more than half a dozen people on the roof at any one time.

The two senior authors are among the pioneers who took the European community psychiatry from ideology and social romanticism into an era of evidence. They established their pioneering research in the 1980s. Since then things have developed, very fast indeed. The Verona/Camberwell model may have had its finest hour. Today's pioneering services are now gradually terminating this model from the 1980s which is not any longer pioneering but traditional. Instead we see establishing of diagnosis-based expert clinics organized within centralized outpatient units. These expert clinics have links to a few intensive beds in wards in general hospitals on the one side and to outreach psychosis teams for long-term patients, most often with schizophrenia, on the other side. This model has several advantages, of which the more important are:

- It can easily intercept and integrate the enormous amount of new knowledge available for updated treatment and not least prevention of the mental brain diseases in its full spectrum.
- It can easily include somatic expertise to the very many psychiatric ill patients who also suffer from physical illnesses.
- It opens the possibility for effective and rational treatment of the majority of psychiatric illnesses, the common mental disorders: depression, anxiety, obsessive-compulsive disorder, and others.

One could ask why services still basing themselves on the hospital model should be encouraged to implement a traditional community model; why not go directly to present times using recent knowledge, or with the poet *"Hence from Verona"* – and maybe from Camberwell too? – *"art thou banished. Be patient,"* – (!?) – *"for the world is broad and wide"*.

European community psychiatry represented by the Italian/British model replaced mental hospitals, asylums, and manicomios. Hard and condescending words were spoken to these replaced services. This was not totally fair. When asylums were established, they were really a shift in paradigms established by idealistic humanistic thinking *alienists*. The fact that they were overtaken by the development is quite another story.

The 1980s model of community psychiatry is at high-risk for ending up in the same position, backwards thinking, obstructing patients from access to new and better treatment. Among the younger generations of psychiatrists, community psychiatry has already been baptised *postal code psychiatry*, and that is not meant as a compliment.

The authors open their paper by declaring that they will exclusively report and discuss their experiences without including evidence based knowledge. Therefore, when doing so, choosing eminence – not the evidence based model – they cannot be criticised for not going into a documented discussion about what really matters: outcome (the patients', not as in the paper, mostly the staff's welfare). But next time the Verona/Camberwell axis publishes a paper, I myself should wish that they discuss, for example, the following:

- How can community psychiatry reach the critical mass of top skilled, highly educated neuropsychiatrists making it possible to keep the organization professionally updated at any time? (1).
- How can psychiatry based on community psychiatry attract psychiatrists? (2).
- How does community psychiatry prevent the much too high prevalence of physical illness and premature death by physical illnesses in mentally ill? (3-5).
- How does community psychiatry stop and prevent the reinstitutionalization seen after change from hospital to community based treatment? (6).
- How does community psychiatry prevent polypharmacy? (7).
- How does community psychiatry stop and prevent the increasing criminality seen among persons with mental diseases since change from hospital to community based treatment? (6).

References

1. Søndergård L. Recruitment problems in psychiatry: just a matter of more exposition? Acta Psychiatr Scand 2007;116:235-7.
2. Malhi GS, Parker GB, Parker K et al. Shrinking away from psychiatry? A survey of Australian medical students' interest in psychiatry. Aust N Zeal J Psychiatry 2002; 36:416-23.
3. Leucht S, Burkard T, Henderson J et al. Physical illness and schizophrenia: a review of the literature. Acta Psyhiatr Scand 2007;116:317-33.
4. Harris EC, Barraclough B. Excess mortality of mental disorder. Br J Psychiatry 1998; 62:247-53.
5. Amaddeo F, Barbui C, Perini G et al. Avoidable mortality of psychiatric patients in an area with a community based system of mental health care. Acta Psychiatr Scand 2007;115:320-5.
6. Priebe S, Badesconyi A, Fioritti A et al. Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. BMJ 2005; 330:123-6.
7. Tomasi R, de Girolamo G, Santone G et al. The prescription of psychotropic drugs in psychiatric residential facilities: a national survey in Italy. Acta Psychiatr Scand 2006; 113:212-23.